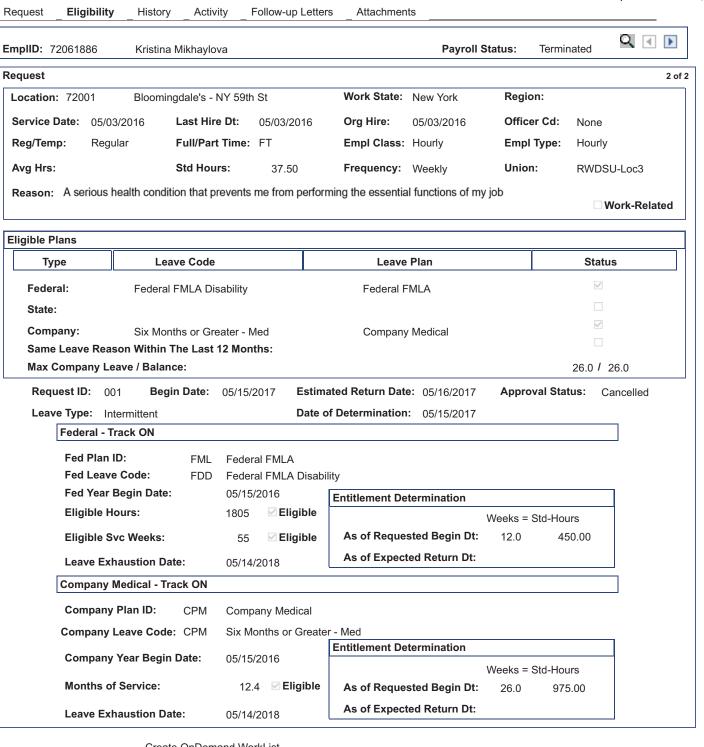


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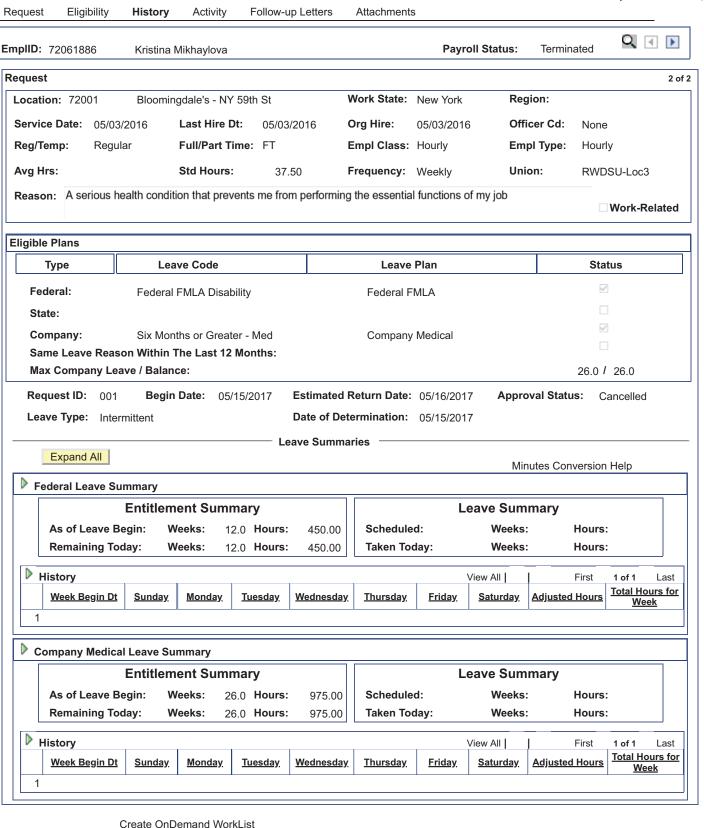
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Company Manual Override





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Request Eligibility History Activity Follow-up Letters Attachments Q 🖪 🕟 EmplID: 72061886 Payroll Status: **Terminated** Kristina Mikhaylova Request 2 of 2 Work State: New York Region: Location: 72001 Bloomingdale's - NY 59th St Service Date: 05/03/2016 Last Hire Dt: 05/03/2016 Org Hire: 05/03/2016 Officer Cd: None Reg/Temp: Full/Part Time: FT Regular Empl Class: Hourly **Empl Type:** Hourly Avg Hrs: Std Hours: 37.50 Frequency: Weekly Union: RWDSU-Loc3 Reason: A serious health condition that prevents me from performing the essential functions of my job Work-Related **Eligible Plans** Type **Leave Code** Leave Plan Status Federal FMLA Federal: Federal FMLA Disability State: Company: Six Months or Greater - Med Company Medical Same Leave Reason Within The Last 12 Months: Max Company Leave / Balance: 26.0 / 26.0 Request ID: 001 Begin Date: 05/15/2017 Estimated Return Date: 05/16/2017 Approval Status: Cancelled Leave Type: Intermittent Date of Determination: 05/15/2017 Insert New Activity Activity Personalize | Find | View All | First 1-6 of 10 Last **Activity Data** Audit Data Follow Up **Activity Date Activity Type** Priority Comments Call Inbound - Insite Self Srv 1 🔲 06/08/2017 Low Help how to enter missing time in Insite// 2 06/08/2017 Leave Status Update Status Changed from PND to CAN Low 3 05/31/2017 Letter Generated Low Attachment type 4601-Fax-LOA request has 05/31/2017 4 Documentation Received Low been inserted. Attachment type 4609-Fax-LOA Final 5 05/31/2017 **Documentation Received** Low Missing Letter has been inserted. 6 05/31/2017 Mail Information Sent Low Letter Sent: Final Notice for Missing Doc

Request | Eligibility | History | Activity | Follow-up Letters | Attachments

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Request Eligibility History Activity Follow-up Letters Attachments Q 🖪 🕟 EmplID: 72061886 Payroll Status: **Terminated** Kristina Mikhaylova Request 2 of 2 Work State: New York Region: Location: 72001 Bloomingdale's - NY 59th St Service Date: 05/03/2016 Last Hire Dt: 05/03/2016 Org Hire: 05/03/2016 Officer Cd: None Full/Part Time: FT Reg/Temp: Regular Empl Class: Hourly **Empl Type:** Hourly Avg Hrs: Std Hours: 37.50 Frequency: Weekly Union: RWDSU-Loc3 Reason: A serious health condition that prevents me from performing the essential functions of my job Work-Related **Eligible Plans** Type **Leave Code** Leave Plan Status Federal FMLA Federal: Federal FMLA Disability State: Company: Six Months or Greater - Med Company Medical Same Leave Reason Within The Last 12 Months: Max Company Leave / Balance: 26.0 / 26.0 Request ID: 001 Begin Date: 05/15/2017 Estimated Return Date: 05/16/2017 Approval Status: Cancelled Leave Type: Intermittent Date of Determination: 05/15/2017 Insert New Activity Activity Personalize | Find | View All | <u>First</u> 7-10 of 10 Last **Activity Data** Audit Data Follow Up **Activity Date Activity Type** Priority Comments new loa// EE call to set new loa// expl how 7 05/15/2017 Call Inbound - Elig/Exten Low to print from Insite// rtrn of CHCP by 05/31// adv look for e-mails for notifications// 8 05/15/2017 New Leave Packet Low Sent via email. Must respond by 5/31/2017. 9 05/15/2017 Leave Status Update Status Changed from OPN to PND Low 05/15/2017 10 Case Manager Iow Case Manager Assigned: L027245

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Request | Eligibility | History | Activity | Follow-up Letters | Attachments

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| equest _ Eligibility | History Activity | Follow-up Letters | Attachments | | | _ |
|---|---------------------------------|-------------------|----------------------------------|-----------------------|--------------------|----------------------|
| mplID: 72061886 | Kristina Mikhaylova | | | Payroll Status: | Terminated Q 4 | Þ |
| quest | | | | | | 2 of |
| Address 1: 7330 1 | 00 Ct Ant 1 | | Address 2: | | | |
| , | 98 St Apt 1 | 04-4- 107 | | | | |
| | Meadows | State: NY | Zip: 1136 | | | |
| elephone: 646/27 | | | mikhaylova@yahoo. | com | | |
| Preferred Contact: | Email | Edit Contac | ct Information | | | |
| Location: 72001 | Bloomingdale's - NY | 59th St | Work State: Ne | w York Region | on: | |
| Service Date: 05/0 | 03/2016 Last Hire D | t: 05/03/2016 | Org Hire: 05 | /03/2016 Offic | er Cd: None | |
| Reg/Temp: Reg | ular Full/Part Ti | me: FT | Empl Class: Ho | urly Empl | Type: Hourly | |
| Avg Hrs: | Std Hours: | 37.50 | Frequency: We | eekly Unio | n: RWDSU-Loc3 | |
| Eligible Plans Type | Leave Code | | Leave Pla | n | Status | |
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| Federal: | Federal FMLA Disab | ility | Federal FML | A | | |
| State: | | | | | | |
| Company: | Six Months or Greate | | Company Me | edical | | |
| Max Company L | eave / Balance: | Months: | | | 26.0 / 26.0 | |
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| Leave Type: Inter | mittent | Date of De | etermination: 05/1 | 5/2017 | | |
| Follow-up Letters Generate Letter | Letter Dates Certified M | ail Comments | <u>F</u> Employee Address Int | Personalize Find | First 1 of 1 Audit | Last |
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Request Eligibility History Activity Follow-up Letters **Attachments** QIII EmplID: 72061886 **Payroll Status:** Terminated Kristina Mikhaylova Request 2 of 2 Location: 72001 Bloomingdale's - NY 59th St Work State: New York Region: Service Date: 05/03/2016 **Last Hire Dt:** 05/03/2016 Org Hire: 05/03/2016 Officer Cd: None Full/Part Time: FT Reg/Temp: Regular Empl Class: Hourly **Empl Type:** Hourly Avg Hrs: Std Hours: Frequency: Weekly Union: 37.50 RWDSU-Loc3 Reason: A serious health condition that prevents me from performing the essential functions of my job ■ Work-Related Eligible Plans Type **Leave Code** Leave Plan **Status** Federal: Federal FMLA Disability Federal FMLA State: Six Months or Greater - Med Company: Company Medical Same Leave Reason Within The Last 12 Months: Max Company Leave / Balance: 26.0 / 26.0 Request ID: 001 Begin Date: 05/15/2017 Estimated Return Date: 05/16/2017 **Approval Status:** Cancelled Leave Type: Intermittent Date of Determination: 05/15/2017 Attachments First Personalize | Find | Т 1-4 of 4 Last Audit Info **Attachment Info Document Create** <u>File</u> View Attached File Attach Code Doc Type Descr OnDemand WL Extension <u>Type</u> 72061886.001.AA Fax-LOA Medical 1 🔊 AAMED 4615 PDF MED.001.pdf documentation/CHCP F_LOA_ATT005.p 2 🗟 F_LOA_ATT005 4601 Fax-LOA request PDF 72061886 kristina Fax-LOA Final 3 🔊 F_LOA_LTR901 4609 PDF _mikhaylova_Fin_ Missing Letter Mis 053117.pdf F_LOA_LTR032.p 4 🏖 F LOA LTR032 4601 PDF Fax-LOA request

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| ★ b Benefits | Loavo of Absonce P.O. Box 17427 Clearwater, FL 33762 Fax: 1-800-310-7740 Ph: 1-800-234-MACY (6229) Email: bloomingdales.loa@bloomingdales.com |
|---|--|
| From: Kristina Mikhaylova Payroll #: 72061886 Date: Number of Pages Install | |
| Number of Pages Including Cover: Comments: | |
| Leave of absence from | due to pregnancy |
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| R Services Leave of Absence | |
| Please include this cove information related to you | er sheet with any or leave of absence. |

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Kristina Mikhaylova

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act) Payroll # 72061885

U.S. Department of Labor Employment Standards Administration Wage STORE #72001

U.S. Wass and Hour Division OMB Control Number: 1215-0181 Expires: 12/31/2011

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-within five business days of the employee notifying the employer of the need for FMLA leave, Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as

[PART A - NOTICE OF ELIGIBILITY]

162

To: Kristina Mikhaylova

From: HR Services - Leave of Absence

Date: 5/16/2017

On 05/15/2017 you informed us that you needed leave beginning on 05/15/2017 for:

- The birth of a child, or placement of a child with you for adoption or foster care;
- [X] Your own serious health condition;
- [] Because you are needed to care for your [] spouse: [] child; [] parent due to his/her serious health condition.
- Because of a qualifying exigency arising out of the fact that your [] spouse; [] son or daughter; [] parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- [] Because you are the [] spouse; [] son or daughter; [] parent; [] next of kin of a covered service member with a serious injury or illness.

This notice is to inform you that you:

- [X] Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
- Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately months towards this requirement.
- [] You have not met the FMLA's 1,250-hours-worked requirement.
- [] You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact HR Services at 1-800-234-MACY or view the FMLA poster located in your store HR location.

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| Kristin | a Mikhavlova | Payroll # 72061886 | Store #72001 | |
|--|--|--|--|---|
| | | RESPONSIBILITIES FOR TAKING | FMLA LEAVE) | |
| availa FMLA must a | ble in the applicable leave, you must reallow at least 15 ca | e 12-month period. However, in order turn the following information to us be lender days from receipt of this notice | or taking FMLA leave and still have FMLA leave er for us to determine whether your absence qualifies as by 5/31/2017. (If a certification is requested, employers e; additional time may be required in some mely manner, your leave may be denied. | |
| [X] Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request [X] is/ [] is not enclosed. | | A leave. A certification form that sets forth the [] is not enclosed. | | |
| [] | Sufficient documentation to establish the required relationship between you and your family member | | ationship between you and your family member. | |
| (1 | Other informatio | n needed: | | |
| | r leave does qual ed blanks apply): | fy as FMLA leave you will have the | following responsibilities while on FMLA leave (only | |
| [x] | arrangements to health benefits v grace period in v insurance may b health coverage | continue to make your share of the hile you are on leave. You have a nation to make premium payments. It is capcalled provided we notify you | enefits at 1-800-234-6229(MACY) to make premium payments on your health insurance to maintain ininimum 30-day (or. indicate longer period, if applicable if payment is not made timely, your group health in writing at least 15 days before the date that your pay your share of the premiums during FMLA leave, urn to work. |) |
| [1] | absence This r | ired to use your available paid [] acc neans that you will receive your paid I counted against your FMLA leave e | rued PTO, and/or [] other leave during your FMLA leave and the leave will also be considered protected entitlement. | |
| [] | "key employee," | restoration to employment may be of ause substantial and grievous econo ou to employment at the conclusion of | dered a "key employee" as defined in the FMLA. As a defined following FMLA leave on the grounds that such omic injury to us. We [] have/[] have not determined of FMLA leave will cause substantial and grievous | |
| [x] | While on leave work every 30 d | you will be required to furnish us with ays. (Indicate interval of periodic re | periodic reports of your status and intent to return to ports, as appropriate for the particular leave situation). | |
| on th | e circumstances on the reverse side of and to report for wo | this form, you will be required to | able to return to work earlier than the date indicated notify us at least two workdays prior to the date you | |
| If yo You | ur leave does qua have a right under | lify as FMLA leave you will have the the FMLA for up to 12 weeks of unpaid the FMLA for up to 12 weeks of unpaid the first terms of the first term | following rights while on FMLA leave: aid leave in a 12-month period calculated as: | |
| 11 | the calendar ye | ar (January – December). | | |
| [] | | par based on | | |
| [] | | eriod measured forward from the da | | |
| [x] | a "rolling" 12-m | onth period measured backward from | m the date of any FMLA leave usage. | |

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Kristina Mikhaylova Payroll # 72061886 Store #72001

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care
 for a covered service member with a serious injury or illness. This single 12-month period commenced on
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as
 if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and
 conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end
 of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered service member's serious injury or lilness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have [] accrued sick days. [x] accrued PTO (as applicable) and/or [x] other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.
- [x] For a copy of conditions applicable to sick days/PTO/other leave usage please refer to the information under your benefits while on leave and/or the company PTO policy.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

1-800-234-MACY (6229)

I acknowledge that when I notified the Company of my need for Family Medical Leave Act, the Company provided me with notice of my rights and obligations and answered any questions I had presented.

Signature of Employee

06/02/13

This form will need to be mailed to:

Date

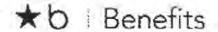
Leave of Absence P.O. Box 17427

Clearwater, FL 33762-0427

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Fax Server P 5/10



Leave of Absence P.O. Box 17427 Clearwater, FL 33762 Fax: 1-800-310-7740 Ph: 1-800-234-MACY (6229)

Email: bioomingdales.loa@bloomingdales.com

5/16/2017

Kristina Mikhaylova 7330 198 St Apt 1 Fresh Meadows, NY 11366

Payroll # 72061886

Dear Kristina:

We have been notified that you are requesting a Leave of Absence for 05/15/2017 to (approximately) 08/14/2017. Enclosed you will find important information about your Leave of Absence and the documentation required in order for the Company to approve and/or continue your leave. It is important that you understand your responsibilities during your leave so please review this information carefully. If you have any questions regarding this information or what is requested, please contact us.

Important – If you have not provided a health care certification your leave will be pending and not approved. All information requested must be mailed or faxed to the HR Services Leave of Absence team to the address above. HR Services will administer your leave request. If you need assistance in completing the forms, or if there are circumstances that prevent you from meeting the deadlines, please call the HR Services Leave of Absence team at 1-800-234-MACY (6229) or your HR Manager as soon as possible. Remember to stay in contact with your HR Manager regarding the status of your leave.

Please complete the following forms, sign and return to HR SERVICES within 15 days.

If we do not receive this information from you within 15 days, your leave may be delayed or denied.

- Certification of Health Care Provider Needed
- Request for Leave of Absence Form Needed
- Notice of Eligibility and Rights & Responsibilities to Employee Request for Family Medical Leave (FMLA) Needed

Short Term Disability Benefit Information

[X] If you are enrolled in a Short Term Disability plan at Macy's and if your leave is approved, you may be eligible to file a claim for Bloomingdale's Short Term Disability Benefit. Please see "Your Benefits While on Leave". Short Term Disability Pay section. If you have any questions about your eligibility please call 1-800-234-MACY (6229).

Sincerely,

Demario J Rodriguez HR Services Leave of Absence Team

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Kristina Mikhavleva Payroll # 72061886 Store #72001

REQUEST FOR LEAVE OF ABSENCE

- You may fax completed forms to HR Services 1-800-310-7740
- . If you need assistance completing the forms, please contact your Human Resource Manager or HR Services at 1-800-234-6229(MACY).

| request that I be granted an: Original Leave of Absence Extension to my Leave of Absence | |
|--|--|
| am requesting my leave for the following reason: To care for my newborn, or the placement of a child work in A serious health condition that prevents me from perform A serious health condition for which I need to providemy spousedomestic partner (as defined bychildparent My disability due to pregnancy or pregnancy related of To care for a qualified ill/injured military service member Military Exigency leave (FMLA) Unpaid leave when spouse is on leave from qualified in Military leave (USERRA) Other: please explain | orming an essential function of my job care for: (Company policy) conditions. er (FMLA) |
| Complete only if requesting leave on an intermittent basis: Intermittent/Reduced hour schedule leave Reason for change in schedule- | Proposed Schedule |
| 1 understand that: 1. If I am granted the leave of absence requested above, I am expe | |

I may not take a leave for the purpose of seeking, accepting or working at another place of employment. I may not accept employment, or be solf-employed, if it is inconsistent with the restrictions provided by my Health Care Provider. Such actions while on a

omployment, or be solf-employed, if it is inconsistent with the restrictions provided by my releast Card Provider. Sold actions while on a FMLA leave, or any other authorized leave, may be subject to discipline up to and including termination.

Insurance premiums that I am responsible for will be deducted automatically from any disability pay or salary continuation benefits I am entitled to receive. I must directly pay any promiums not collected via payroll deductions, to Bloomingdale's. Failure to pay any insurance promiums due may result in my loss of insurance coverage.

For certain leaves, I may be required to exhaust all applicable paid time off first. This may include PTO, holidays, or any other paid leave available to me. Please refer to the paid time off policy for accrual while on leave of absonce.

I must contact my Human Resource Manager and HR Services at least 2 wooks prior if possible and no later than 2 (two) business.

6. days prior to the date indicated as my return to work date. Failure to do so may result in a delay in my return to work.

It is my obligation to notify HR Services of any change of address during my leave, 7.

| Employee Signature: Alustry Mann | Date: 06/02113 | |
|----------------------------------|----------------|--|
| | | |

You may fax completed forms to 1-800-310-7740 or bloomingdales.lea@bloomingdales.com. If you need assistance completing the forms, please contact your Human Resource Manager or HR Services at 1-800-234-8229 (MACY).

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| Santhakann | remi | 26/01/ | 2010 |
| Signature of Health Care Provider | | Date | 201 |

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

Page 3

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| | Kristina Mikhaylova Payroll # 72061886 | Store #72001 |
|--------|---|---|
| P. | PART BEAMOUNT OF FEAMENPEDED | |
| 5. | Will the employee be incapacitated for a single continuous period of time, include recovery? Y-No [] Yes | ding any time for treatment and |
| | If so, estimate the beginning and ending dates for the period of incapacity: | |
| 6. | 6. Will the employee need to attend follow-up treatment appointments or work part because of the employee's medical condition? ANO [] Yes | t-time or on a reduced schedule |
| | If so, are the treatments or the reduced number of hours of work medically neces | ssary? No [] Yes |
| | Estimate treatment schedule, if any, including the dates of any scheduled appoint each appointment, including any recovery period: | 1.1 |
| | 28 weeks and onery sweek | 1, VOAAOOO |
| | Estimate the part-time or reduced work schedule the employee needs, if any; hours per day days per week from to | adenney |
| 7. | 7. Will the condition cause episodic flare-ups periodically preventing the employee functions? [] No XYes | from performing his/her job |
| | Is it medically necessary for the employee to be absent from work during the fla If so, explain: | |
| | - Namea because of U | of premary |
| | Based upon the patient's medical history and your knowledge of the medical corflare-ups and the duration of related incapacity that the patient may have over the every 3 months lasting 1-2 days): | ndition, estimate the frequency of e next 6 months (e.g., 1 episode |
| | Frequency: times per week(s) month(s) | |
| water! | Duration; hours or days per episode | CRA PRINTED TO THE TOTAL PRINTED TO THE WARRANT OF THE PRINTED TO |
| S.I | ADDITIONAL INFORMATION INDENTITY OUESTION NUMBER WITTEN OL | RADDITIONALANSWER |
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Kristina Mikhaylova

Payroll # 72061886

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor Employment Standards Administration Wage and Hour Division



SECRETOR OF THE PROPERTY OF TH

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

| Employer name and contact: | Bloomingdale's HR Services Leave of Absence, I-800-234-MACY (6229) | | | |
|---------------------------------|--|--|--|--|
| Employee's Job title: | Regular work schedule: | | | |
| Employee's essential job functi | ons: | | | |

Check if job description is attached: []

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INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request, 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

| Your name: | Kristina | | Mikhaylova | |
|------------|----------|--------|------------|--|
| | First | Middle | Last | |

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INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime." "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage, Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Further Instructions to the Healthcare Provider as added by the Company: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide genetic information when responding to this request for medical information, "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

| Provider's name and business address | s: Santtre Kanningiri 10 | LE-20 ALLEUN BLVD |
|---------------------------------------|--------------------------|-------------------|
| Type of practice / Medical specialty: | | Sunto 10 |
| Telephone: 71x 275 2 | 677 + Fax: (718 975 267 | 3 CAUTHILLA |
| Page 1 | CONTINUED ON NEXT PAGE | 2 11 20 17 10 K |
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| RT A: Medical Fac | Kristina Mikhaylova | Payroll # 72061886 | Store: #7200 |
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| approximate date at | 63 15 201 | 7 | |
| Probable duration o | foondition | | |
| Probable duration o | continui cuntit | 11/22/207 | |
| | -F-10F-0-7 | 4 | |
| Mark below as app | olicable: | hospital, hospice, or residential medi | cal care facility? |
| No [] Yes, If so | o, dates of admission: | , respectively and a second | 200 0000 2000 |
| | | | |
| Date(s) you treated | the patient for condition: | 1 | |
| 10 | 6/2017 5/0 | 3/2017 | |
| Was medication of | her than over-the-counter medic | eation, prescribed? [] No MYes | |
| | | , | 0 11N- 16347aa |
| Will the patient nee | ed to have treatment visits at least | st twice per year due to the condition | I I No Mics |
| Was the patient ref | erred to other health care provid | ler(s) for evaluation or treatment (e.g. | , physical therapist)? |
| No [] Yes, If s | o, state the nature of such treatm | nents and expected duration of treatm | ient: |
| | | | |
| | | | |
| | Wilson and Mark Mark | . If so, expected delivery date: 17 | 22/201 |
| | | | |
| Leave may be available | able for either baby bonding or in | the event of a serious health condition | Please indicate the |
| amount of time off n | eeded for each calegory: | | |
| | | | |
| Baby bonding | | | |
| | dition All-A | | |
| Serious Health Con | | provide updated medical certification. | |
| Serious Health Con | hanges during the leave, please p | provide updated medicol certification. | |
| Serious Health Con | hanges during the leave, please p | Section I to answer this question. If th | e employer fails to |
| Serious Health Con If this information of Use the information provide a list of th | nanges during the leave, please p n provided by the employer in S e employee's essential functions | Section I to answer this question. If the sor a job description, answer these questions | e employer fails to sestions based upon the |
| Serious Health Con If this information of Use the informatio provide a list of the employee's own de | nanges during the leave, please p in provided by the employer in S is employee's essential functions escription of his/her job function | Section I to answer this question. If the sor a job description, answer these questions. | Appliant provide all |
| Serious Health Con If this information of Use the informatio provide a list of the employee's own de- | nanges during the leave, please p in provided by the employer in S is employee's essential functions escription of his/her job function | Section I to answer this question. If the sor a job description, answer these questions | Appliant provide all |
| Serious Health Con If this information of Use the informatio provide a list of th employee's own de Is the employee un | nanges during the leave, please p in provided by the employer in S is employee's essential functions escription of his/her job function hable to perform any of his/her j | Section I to answer this question. If the sor a job description, answer these qualities. Sob functions due to the condition? [| Appliant provide all |
| Serious Health Con If this information of Use the informatio provide a list of the employee's own de Is the employee un If so, identify the | nanges during the leave, please p in provided by the employer in S is employed's essential functions escription of his/her job function hable to perform any of his/her j job functions the employed is un | Section I to answer this question. If the sor a job description, answer these questions. The solution is the condition of th |] No IX Yes. |
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Kristina Mikhaylova Payroll # 72061886 Store #72001

Certification of Health Care Provider for Associate's Medical Condition

| Please return completed form to: | | Date Issued: 6/1/2017 | |
|--|--|--|---|
| □ HR Services-P.O. Box 17427-Clearwater, | □ Associate's Illness/Disability | | |
| Facsimile 800-310-7740 | □ Work Incurred Illness/Disability | | |
| □ HR Services-P.O. Box 8060-Mason, OH 45040 | | □ ADA Accomodation | |
| Facsimile 800-283-3730 | | | |
| Associate's Name: Kristina | Mikh | aylova | Associate # 72061886 |
| First | Middle | Last | |
| Telephone #: | Store/ | Location: 72001 | |
| Physician's Name (Print): | | | |
| Office address: | | | |
| City, State, Zip Code: | | | |
| | | | |
| Telephone #: | | Facsimile #: | |
| | | | |
| Physician's Signature | | Date: | |
| | | | |
| Instructions For Completion by the HEAL | TH CARE P | PROVIDER | |
| their medical condition. Please answer, fully response as to the frequency or duration of a cestimate based upon your medical knowledge you can; terms such as "lifetime," "unknown, under Company policy. Limit your responses Please be sure to sign and date the form on the | and complete condition, tre , experience, " or "indetern to the condit | ely, all applicable parts. atment, etc. Your answe and examination of the prinate may not be suffice | Several questions seek a r should be your best patient. Be as specific as ient to determine coverage |
| The Genetic Information Nondiscrimination A covered by GINA Title II from requesting or softhe individual, except as specifically allowed not provide genetic information when respond Information" as defined by GINA, includes an individual's or family member's genetic tests, or received genetic services, and genetic inforfamily member or an embryo lawfully held by reproductive services. | requiring geneed by this law ding to this remaindividual's the fact that a contact that a | etic information of an inex. To comply with this land equest for medical information family medical history, an individual or individual etus carried by an individual | dividual or family member aw, we are asking that you ation. "Genetic the results of an al's family member sought dual or an individual's |
| | | | |
| Type of practice / Medical specialty: | | | |
| Telephone: () | Fa | x: () | |

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Kristina Mikhaylova Payroll # 72061886 Store #72001

| 1. | Approximate date condition commenced: |
|----|---|
| | Probable duration of condition: |
| | Mark below as applicable: Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? [] No [] Yes. If so, dates of admission: |
| | Date(s) you treated the patient for condition: |
| | Was medication, other than over-the-counter medication, prescribed? [] No [] Yes |
| | Will the patient need to have treatment visits at least twice per year due to the condition? [] No [] Yes |
| | Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? [] No [] Yes. If so, state the nature of such treatments and expected duration of treatment. |
| 2. | Is the medical condition pregnancy? [] No [] Yes. If so, expected delivery date: Leave may be available for either baby bonding or in the event of a serious health condition. Please indicate the amount of time off needed for each category: |
| | Baby bonding |
| | Serious Health Condition |
| | If this information changes during the leave, please provide updated medical certification. |
| 3. | Is the employee unable to perform any of his/her job functions due to the condition? [] No [] Yes. |
| | If so, identify the job functions the employee is unable to perform: |
| 4. | Describe other relevant facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): |
| | |
| PA | RT B: AMOUNT OF LEAVE NEEDED |
| 5. | Will the employee be incapacitated for a single continuous period of time, including any time for treatment and recovery? [] No [] Yes |
| | If so, estimate the beginning and ending dates for the period of incapacity: |

Case 1:19-cv-08927-GBD-SLC Document 143-1 Filed 10/31/23 Page 20 of 53

Kristina Mikhaylova Payroll # 72061886 Store #72001

| 6. | Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule be employee's medical condition? [] No [] Yes | because of the |
|-----|---|----------------|
| | If so, are the treatments or the reduced number of hours of work medically necessary? [] No [] Yes | |
| 7. | Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for appointment, including any recovery period: | each |
| 8. | Estimate the part-time or reduced work schedule the employee needs, if any: hours per day days per week from to | |
| 9. | Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job fur No [] Yes | actions? [] |
| | Is it medically necessary for the employee to be absent from work during the flare-ups? [] No Yes If so, explain: | |
| 10. | Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 month days): | |
| | Frequency: times per week(s) month(s) | |
| | Duration: hours or days per episode | |
| AD | DDITIONAL INFORMATION: | |
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| Sig | enature of Health Care Provider Date | |



Leave of Absence P.O. Box 17427 Clearwater, FL 33762-0427 Ph: 1-800-234-MACY

Fax: 1-800-310-7740

 $E\hbox{-}Mail: blooming dales.loa@blooming dales.com\\$

June 01, 2017 Payroll # 72061886

Kristina Mikhaylova 7330 198 St Apt 1 Fresh Meadows, NY 11366

Dear Kristina,

In our previous letter to you dated May 16, 2017 we requested you provide us with information required to update your leave of absence status. The letter indicated we needed the information from you within 15 days or by May 31, 2017, and asked you to call if you would be unable to get the information within the required time frame. You needed to send:

| ٠, | Completed Health Care Provider's Certification |
|----|--|
| | Completed Certification of Qualifying Exigency For Military Family Leave |
| | Completed Reasonable Accommodation Inquiry |

As of today, we have not received the requested information from you, nor have we received a call from you to make other arrangements. Because you have not submitted the requested information necessary to support your need for a leave of absence, your absence from work is considered unauthorized. If we do not receive the requested information within 3 days of receipt of this letter we will process your separation from the company effective June 12, 2017. Your employee discount will terminate as of this date as well. If you have medical benefits, HR Services/Benefits will send you information regarding your Benefits and continued coverage under the provisions of COBRA. Specific questions regarding your Benefits may be directed to 1-800-234-MACY (6229).

If your leave request was for intermittent leave and you are currently working, you must provide us with the documentation requested above to avoid the application of the Company's regular attendance policies.

If you have any questions regarding your separation from the company, or anything else, please contact your Human Resource Manager. If you submitted the requested information in the required time frame and feel this action has been taken in error, please contact us immediately at 1-800-234-MACY (6229).

Sincerely,

Demario J Rodriguez HR Services, Leave of Absence Certified Number: 70112970000411714922

LTR901 - Non CA Final Missing revised 9.27.12



Leave of Absence P.O. Box 17427 Clearwater, FL 33762 Fax: 1-800-310-7740 Ph: 1-800-234-MACY (6229)

Email: bloomingdales.loa@bloomingdales.com

5/16/2017

Kristina Mikhaylova 7330 198 St Apt 1 Fresh Meadows, NY 11366

Payroll # 72061886

Dear Kristina:

We have been notified that you are requesting a Leave of Absence for 05/15/2017 to (approximately) 08/14/2017. Enclosed you will find important information about your Leave of Absence and the documentation required in order for the Company to approve and/or continue your leave. It is important that you understand your responsibilities during your leave so please review this information carefully. If you have any questions regarding this information or what is requested, please contact us.

Important – If you have not provided a health care certification your leave will be pending and not approved. All information requested must be mailed or faxed to the HR Services Leave of Absence team to the address above. HR Services will administer your leave request. If you need assistance in completing the forms, or if there are circumstances that prevent you from meeting the deadlines, please call the HR Services Leave of Absence team at 1-800-234-MACY (6229) or your HR Manager as soon as possible. Remember to stay in contact with your HR Manager regarding the status of your leave.

Please complete the following forms, sign and return to HR SERVICES within 15 days.

If we do not receive this information from you within 15 days, your leave may be delayed or denied.

- Certification of Health Care Provider Needed
- Request for Leave of Absence Form Needed
- Notice of Eligibility and Rights & Responsibilities to Employee Request for Family Medical Leave (FMLA) Needed

Short Term Disability Benefit Information

[X] If you are enrolled in a Short Term Disability plan at Macy's and if your leave is approved, you may be eligible to file a claim for Bloomingdale's Short Term Disability Benefit. Please see "Your Benefits While on Leave", Short Term Disability Pay section. If you have any questions about your eligibility please call 1-800-234-MACY (6229).

Sincerely,

Demario J Rodriguez HR Services Leave of Absence Team



Leave of Absence P.O. Box 17427 Clearwater, FL 33762 Fax: 1-800-310-7740

Ph: 1-800-234-MACY (6229) Email: bloomingdales.loa@bloomingdales.com

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| LID Cor | vises Leave of Absonce |
| | vices Leave of Absence |
| Fax #: | 1-800-310-7740 |
| | |
| | Please include this cover sheet with any |
| iı | nformation related to your leave of absence. |
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<u>Kristina Mikhavlova</u>

Pavroll # 72061886_

Store #72001

Certification of Health Care Provider for U.S. Department of Labor **Employee's Serious Health Condition** (Family and Medical Leave Act)

Employment Standards Administration Wage and Hour Division

Bloomingdale&apos:s HR Services Leave of Absence, 1-800-234-MACY (6229)



SECTION I: For completion by the EMPLOYER

Employer name and contact:

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

| 1 3 | | |
|--|---|--|
| Employee's jo | b title: | Regular work schedule: |
| Employee's es | sential job fund | ons: |
| Check if job d | escription is at | ched: [] |
| SECTION II: | : For completi | by the EMPLOYEE |
| The FMLA per support a required to complete and s | ermits an emplo est for FMLA obtain or retain sufficient medi | PLOYEE: Please complete Section II before giving this form to your medical provider. For to require that you submit a timely, complete, and sufficient medical certification to ave due to your own serious health condition. If requested by your employer, your response the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a l certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your to talendar days to return this form. 29 C.F.R. § 825.305(b). |
| Your name: | Kristina | Mikhaylova |
| | First | Middle Last |
| SECTION III | I: For complet | n by the HEALTH CARE PROVIDER |
| fully and compoundation, treat examination of sufficient to describe the su | pletely, all appl tment, etc. Yo f the patient. E etermine FMLA | LTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, able parts. Several questions seek a response as to the frequency or duration of a answer should be your best estimate based upon your medical knowledge, experience, and as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be coverage. Limit your responses to the condition for which the employee is seeking leave. on the last page. |
| Nondiscrimina or requiring go this law. To c for medical in results of an ir or received ge | ation Act of 20 enetic informat omply with this formation. "Ge ndividual's or fa netic services, | Iealthcare Provider as added by the Company: The Genetic Information (GINA) prohibits employers and other entities covered by GINA Title II from requesting n of an individual or family member of the individual, except as specifically allowed by aw, we are asking that you not provide genetic information when responding to this request tic Information" as defined by GINA, includes an individual's family medical history, the tily member's genetic tests, the fact that an individual or individual's family member sought d genetic information of a fetus carried by an individual or an individual's family member an individual or family member receiving assistive reproductive services. |
| Provider's nan | ne and business | ddress: |
| Type of practi | ce / Medical sp | cialty: |
| Telephone: | () | Fax: () |
| Page 1 | | CONTINUED ON NEXT PAGE |

| Kristina Mikhaylova Payroll # 72061886 Store #7200 | | | | |
|---|--|--|--|--|
| RT A: Medical Facts Approximate date condition commenced: | | | | |
| Probable duration of condition: | | | | |
| Mark below as applicable: Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? [] No [] Yes. If so, dates of admission: | | | | |
| Date(s) you treated the patient for condition: | | | | |
| Was medication, other than over-the-counter medication, prescribed? [] No [] Yes | | | | |
| Will the patient need to have treatment visits at least twice per year due to the condition? [] No [] Yes | | | | |
| Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? [] No [] Yes. If so, state the nature of such treatments and expected duration of treatment: | | | | |
| Is the medical condition pregnancy? [] No [] Yes. If so, expected delivery date: Leave may be available for either baby bonding or in the event of a serious health condition. Please indicate the | | | | |
| amount of time off needed for each category: | | | | |
| Baby bonding | | | | |
| Serious Health Condition | | | | |
| If this information changes during the leave, please provide updated medical certification. | | | | |
| Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions. | | | | |
| Is the employee unable to perform any of his/her job functions due to the condition? [] No [] Yes. | | | | |
| If so, identify the job functions the employee is unable to perform: | | | | |
| Describe other relevant facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): | | | | |
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Page 2

| Kristina Mikhavlova | Payroll # 72061886 | Store #72001 |
|----------------------------|---------------------|--------------|
| ixi istilia iviikila yluva | 1 ay1011 # 12001000 | Store #12001 |

| 5. | Will the employee be incapacitated for a single continuous period of time, including any time for treatment and recovery? $[\]$ No $[\]$ Yes |
|----|---|
| | If so, estimate the beginning and ending dates for the period of incapacity: |
| 6. | Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? [] No [] Yes |
| | If so, are the treatments or the reduced number of hours of work medically necessary? [] No [] Yes |
| | Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: |
| 7. | Estimate the part-time or reduced work schedule the employee needs, if any: hours per day days per week from to Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? [] No [] Yes Is it medically necessary for the employee to be absent from work during the flare-ups? [] No Yes |
| | If so, explain: |
| | Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days): |
| | Frequency: times per week(s) month(s) |
| | Duration: hours or days per episode |
| ΑI | DITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER |

Page 3

CONTINUED ON NEXT PAGE

| | Kristina Mikhaylova | <u>Payroll # 72061886</u> | Store #72001 |
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| Signature of Health Care Provide | er | Date | |

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

Page 4

Kristina Mikhaylova Payroll # 72061886 Store #7200

REQUEST FOR LEAVE OF ABSENCE

- You may fax completed forms to HR Services 1-800-310-7740
- If you need assistance completing the forms, please contact your Human Resource Manager or HR Services at 1-800-234-6229(MACY).

| Date | Leave to Begin: | (Approximate) Da | ate Leave to End: | |
|-------|--|---|---|-----------------------------|
| | I request that I be grante Original Leave of Extension to my I | Absence | | |
| I am | requesting my leave for | r the following reason: | | |
| / | A serious health condition A serious health condition | | | job |
| " Т | | gnancy or pregnancy related injured military service men | | |
| N | Inpaid leave when spou filitary leave (USERRA) | ise is on leave from qualifie | | |
| | nplete only if requesting leavermittent/Reduced hour sche | | Proposed Schedule | |
| | eason for change in schedule | | Froposed Scriedule | |
| l uno | derstand that: | | | |
| 1. | leave is to end. If I cannot ret Resources Manager. I agree t Manager and/or HR Services | urn to work on this date, I must requesto submit any additional supporting meto support my leave of absence and/o | | and Human Human Resource |
| 2. | business needs. | | ed leave of absence unless my position is eliminate | |
| 3. | employment, or be self-emplo | | r working at another place of employment. I may notions provided by my Health Care Provider. Such a coline up to and including termination. | |
| 4. | Insurance premiums that entitled to receive. I must dire | I am responsible for will be deducted | automatically from any disability pay or salary cont via payroll deductions, to Bloomingdale's. Fa | |
| 5. | For certain leaves, I may | | paid time off first. This may include PTO, holidays | , or any other paid |
| 6. | I must contact my Human days prior to the date indicate | n Resource Manager and HR Services das my return to work date. Failure to | s at least 2 weeks prior if possible and no later than o do so may result in a delay in my return to work. | 1 2 (two) business |
| 7. | It is my obligation to notif | y HR Services of any change of addre | ess during my leave. | |
| | | | | |

What Next?

Employee Signature:

You may fax completed forms to 1-800-310-7740 or bloomingdales.loa@bloomingdales.com. If you need assistance completing the forms, please contact your Human Resource Manager or HR Services at 1-800-234-6229(MACY).

Date:

Kristina Mikhaylova
Notice of Eligibility and
Rights & Responsibilities
(Family and Medical Leave
Act)

Payroll # 72061886
U.S. Department
of Labor
Employment
Standards
Administration Wage
and Hour Division



In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[PART A – NOTICE OF ELIGIBILITY]

To: Kristina Mikhaylova

From: HR Services - Leave of Absence

Date: 5/16/2017

On 05/15/2017 you informed us that you needed leave beginning on 05/15/2017 for:

- The birth of a child, or placement of a child with you for adoption or foster care;

 Your own serious health condition;

 Because you are needed to care for your [] spouse; [] child; [] parent due to his/her serious health condition.
- Because of a qualifying exigency arising out of the fact that your [] spouse; [] son or daughter; [] parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- Because you are the [] spouse; [] son or daughter; [] parent; [] next of kin of a covered service member with a serious injury or illness.

This notice is to inform you that you:

- [X] Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
- [] Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- [] You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately months towards this requirement.
- [] You have not met the FMLA's 1,250-hours-worked requirement.
- [] You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact HR Services at 1-800-234-MACY or view the FMLA poster located in your store HR location.

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<u>Kristina Mikhaylova</u> <u>Payroll # 72061886</u> <u>Store #72001</u> [PART B – RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

checked blanks apply):

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by 5/31/2017. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

| [X] | Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request [X] is/[] is not enclosed. | |
|--|--|--|
| [] | Sufficient documentation to establish the required relationship between you and your family member. | |
| [] | Other information needed: | |
| f your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only | | |

- [x] If you are enrolled in benefits contact HR Services/Benefits at 1-800-234-6229(MACY) to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.
- [] You will be required to use your available paid [] accrued PTO, and/or [] other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.
- [] Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We [] have/[] have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.
- [x] While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every 30 days. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave changes and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave: You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:

| [] | the calendar year (January – December). |
|-----|--|
| [] | a fixed leave year based on |
| [] | the 12-month period measured forward from the date of your first FMLA leave usage. |
| [x] | a "rolling" 12-month period measured backward from the date of any FMLA leave usage. |

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Kristina Mikhaylova______Payroll # 72061886______Store #72001

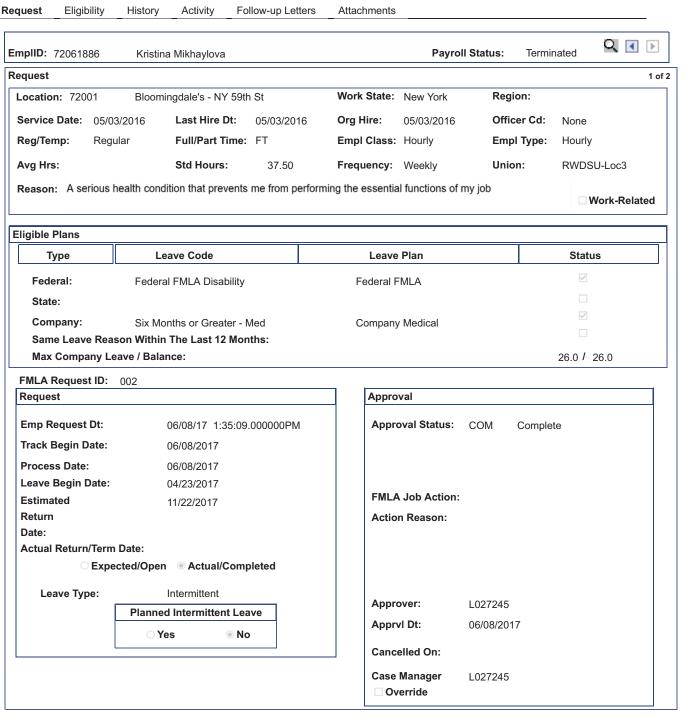
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered service member with a serious injury or illness. This single 12-month period commenced on
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as
 if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered service member's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- if we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have [] accrued sick days, [x] accrued PTO (as applicable) and/or [x] other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.
- [x] For a copy of conditions applicable to sick days/PTO/other leave usage please refer to the information under your benefits while on leave and/or the company PTO policy.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

1-800-234-MACY (6229)

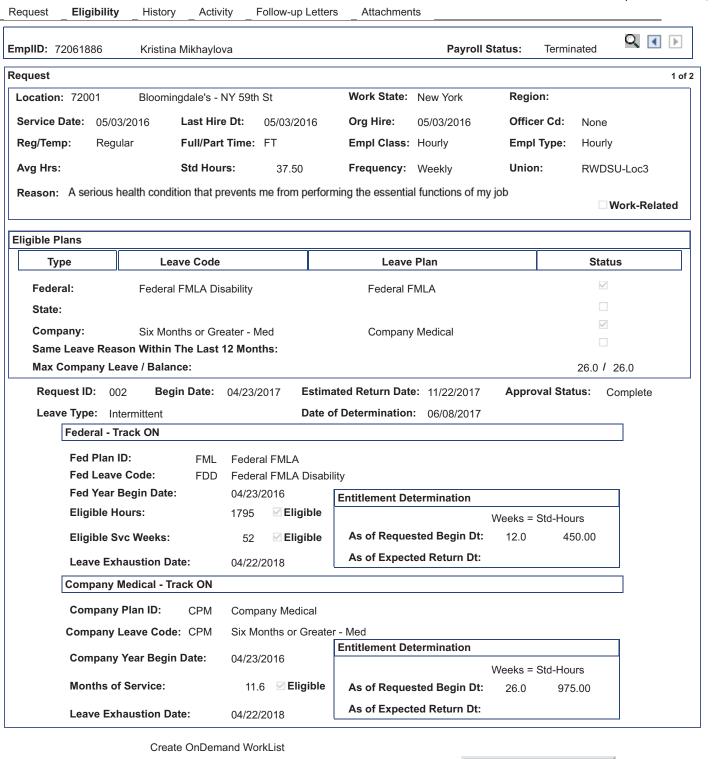
| I acknowledge that when I notified the Co of my rights and obligations and answere | empany of my need for Family Medical Leave Act, the Company provided me with notice d any questions I had presented. |
|--|--|
| Date | Signature of Employee |
| This form will need to be mailed to: | Leave of Absence P.O. Box 17427 |

Clearwater, FL 33762-0427



Create OnDemand WorkList

Save Return to Search Previous in List



Company Manual Override

Save Return to Search Previous in List Next in List

Eligibility Activity Follow-up Letters Attachments Request History Q 🖪 🕨 **Payroll Status: Terminated** EmplID: 72061886 Kristina Mikhaylova Request 1 of 2 Work State: New York Location: 72001 Region: Bloomingdale's - NY 59th St **Service Date:** 05/03/2016 **Last Hire Dt:** Org Hire: Officer Cd: 05/03/2016 05/03/2016 None Reg/Temp: Full/Part Time: FT Regular Empl Class: Hourly **Empl Type:** Hourly Avg Hrs: Std Hours: 37.50 Frequency: Weekly Union: RWDSU-Loc3 Reason: A serious health condition that prevents me from performing the essential functions of my job ■ Work-Related Eligible Plans Type **Leave Code** Leave Plan **Status** Federal: Federal FMLA Disability Federal FMLA State: Six Months or Greater - Med Company Medical Company: Same Leave Reason Within The Last 12 Months: Max Company Leave / Balance: 26.0 / 26.0 Request ID: 002 Begin Date: 04/23/2017 Estimated Return Date: 11/22/2017 **Approval Status:** Complete Leave Type: Intermittent Date of Determination: 06/08/2017 **Leave Summaries** Expand All Minutes Conversion Help Federal Leave Summary **Leave Summary Entitlement Summary** As of Leave Begin: Scheduled: Weeks: Weeks: 12.0 **Hours**: 450.00 Hours: **Remaining Today:** Weeks: 450.00 Taken Today: Weeks: 12.0 Hours: Hours: History View All First Last 1 of 1 **Total Hours for** Week Begin Dt **Adjusted Hours** Sunday. Monday. Tuesday **Wednesday Thursday** Friday. <u>Saturday</u> <u>Week</u> Company Medical Leave Summary **Entitlement Summary Leave Summary** As of Leave Begin: Scheduled: Weeks: Weeks: 26.0 Hours: 975.00 Hours: Remaining Today: Weeks: 26.0 Hours: 975.00 Taken Today: Weeks: Hours: \triangleright History View All First 1 of 1 Last Total Hours for Week Week Begin Dt Sunday. **Monday Tuesday Wednesday** Thursday. Friday Saturday. **Adjusted Hours** 1 Create OnDemand WorkList

Save Return to Search Previous in List

Request Eligibility History Activity Follow-up Letters Attachments Q 🖪 🕨 EmplID: 72061886 Payroll Status: **Terminated** Kristina Mikhaylova Request 1 of 2 Location: 72001 Bloomingdale's - NY 59th St Work State: New York Region: **Service Date:** 05/03/2016 Last Hire Dt: 05/03/2016 Org Hire: 05/03/2016 Officer Cd: None Reg/Temp: Regular Full/Part Time: FT Empl Class: Hourly **Empl Type:** Hourly Avg Hrs: Std Hours: 37.50 Frequency: Weekly Union: RWDSU-Loc3 Reason: A serious health condition that prevents me from performing the essential functions of my job ■ Work-Related Eligible Plans Type **Leave Code** Leave Plan **Status** Federal: Federal FMLA Federal FMLA Disability State: Company: Six Months or Greater - Med Company Medical Same Leave Reason Within The Last 12 Months: Max Company Leave / Balance: 26.0 / 26.0 Request ID: 002 Begin Date: 04/23/2017 Estimated Return Date: 11/22/2017 **Approval Status:** Complete Leave Type: Intermittent Date of Determination: 06/08/2017 Insert New Activity Activity Personalize | Find | View All | First 1-6 of 12 Last | EEE | **Activity Data** Audit Data Follow Up | Activity Date Activity Type **Priority Start Date End Date** Comments Rec'd returned Cert mail (Final 07/21/2017 Missing tr dtd 6/01/17). 1 Returned Mail Low Unclaimed. 2 06/20/2017 Follow up Completed completed per term report Low Status Changed from APP to 3 06/20/2017 Leave Status Update Low COM 5 time per 1 week 6 months 4 06/20/2017 Int. FMLA frequency Low 2 hours per episode 5 06/08/2017 Follow Up Needed Low 11/23/2017 11/23/2017 COM leave 06/08/2017 11/01/2017 11/01/2017 send Fut Exp Letter 6 Follow Up Needed Low

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Request Eligibility History Activity Follow-up Letters Attachments Q 🖪 🕟 EmplID: 72061886 Payroll Status: **Terminated** Kristina Mikhaylova Request 1 of 2 Location: 72001 Work State: Bloomingdale's - NY 59th St New York Region: **Service Date:** 05/03/2016 Last Hire Dt: 05/03/2016 Org Hire: 05/03/2016 Officer Cd: None Reg/Temp: Regular Full/Part Time: FT Empl Class: Hourly **Empl Type:** Hourly Avg Hrs: Std Hours: Frequency: Weekly Union: 37.50 RWDSU-Loc3 Reason: A serious health condition that prevents me from performing the essential functions of my job ■ Work-Related Eligible Plans Type **Leave Code** Leave Plan **Status** Federal: Federal FMLA Federal FMLA Disability State: Company: Six Months or Greater - Med Company Medical Same Leave Reason Within The Last 12 Months: Max Company Leave / Balance: 26.0 / 26.0 Request ID: 002 Begin Date: 04/23/2017 Estimated Return Date: 11/22/2017 **Approval Status:** Complete Leave Type: Intermittent Date of Determination: 06/08/2017 Insert New Activity Activity Personalize | Find | View All | First 7-12 of 12 Last | EEE | **Activity Data** Audit Data Follow Up | Activity Date **Activity Type Priority Start Date** End Date Comments 7 06/08/2017 Approval Letter Low Sent via mail. Attachment type 4606-Fax-LOA 06/08/2017 8 Documentation Received Low Approval Letter has been inserted. Status Changed from PND to 9 06/08/2017 Leave Status Update Low Sent via email. Must respond by 10 06/08/2017 **New Leave Packet** Low 6/24/2017. Status Changed from OPN to 11 🗆 06/08/2017 Leave Status Update Low PND Case Manager Assigned: 12 06/08/2017 Iow Case Manager L027245

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Return to Audit Work List

Save Return to Search Previous in List

New Window | Personalize Page Request Eligibility History Activity Follow-up Letters Attachments Q 🖪 🖪 EmplID: 72061886 **Payroll Status:** Terminated Kristina Mikhaylova Request 1 of 2 Address 1: Address 2: 7330 198 St Apt 1 City: Fresh Meadows State: NY Zip: 11366 Telephone: 646/270-0228 Email: kristinamikhaylova@yahoo.com Preferred Contact: Email **Edit Contact Information** Work State: New York Location: 72001 Bloomingdale's - NY 59th St Region: Service Date: 05/03/2016 Last Hire Dt: Org Hire: 05/03/2016 Officer Cd: 05/03/2016 None Full/Part Time: FT Reg/Temp: Regular Empl Class: Hourly **Empl Type:** Hourly Frequency: Weekly Avg Hrs: Std Hours: 37.50 Union: RWDSU-Loc3 Reason: A serious health condition that prevents me from performing the essential functions of my job ■ Work-Related Eligible Plans Type **Leave Code** Leave Plan **Status** Federal: Federal FMLA Disability Federal FMLA State: Company: Six Months or Greater - Med Company Medical Same Leave Reason Within The Last 12 Months: Max Company Leave / Balance: 26.0 / 26.0 Estimated Return Date: 11/22/2017 Begin Date: 04/23/2017 **Approval Status:** Request ID: 002 Complete Leave Type: Intermittent Date of Determination: 06/08/2017 Follow-up Letters Personalize | Find | First 1 of 1 Last **Generate Letter** Letter Dates Certified Mail Comments Employee Address Info HR Services Info Audit

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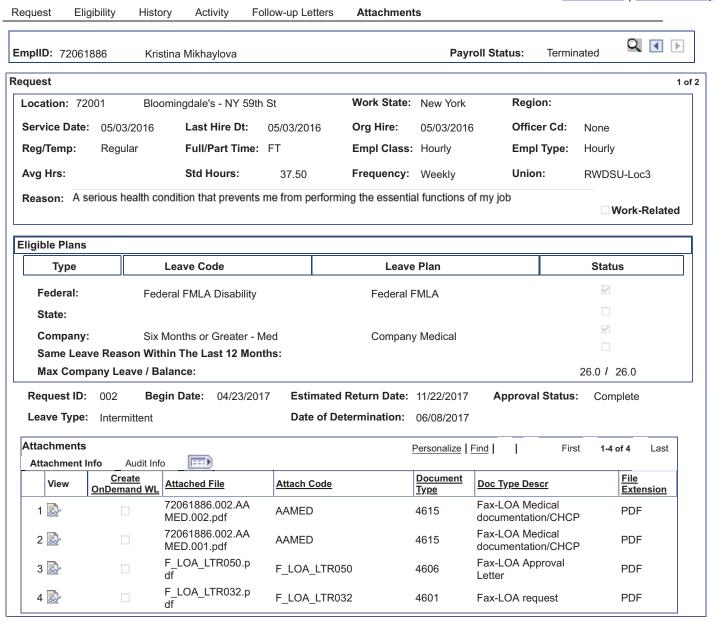
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Request | Eligibility | History | Activity | Follow-up Letters | Attachments

Delivery Method <u>Letter</u> <u>Sent</u>

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Create OnDemand WorkList



Request | Eligibility | History | Activity | Follow-up Letters | Attachments

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| No. of | O | 1 | Benefits | |

Leave of Absence P.O. Box 17427 Clearwater, FL 33762 Fax: 1-800-310-7740

Fh: 1-800-234-MACY (6229) Email: bloomingdales.los@bloomingdales.com

Payroll #: 72061886

Date:

Number of Pages Including Cover:

Comments:

Leave of absence was due to pregnancy

HR Services Leave of hisence

Please include this cover sheet with any information related to your leave of absence.

Case 1:19-cv-08927-GBD-SLC Document 143-1 Filed 10/31/23 Page 40 of 53

| | |) | | - | Store #72001 |
|------|---|-----------------------|---|---------------------|-----------------------|
| | Krist | il Nikhaylaya | Payroll # 7206 | 886 | |
| | | an sita | | | |
| RE | REPRODUCED WEEKING | IN PACES | demons period of time. | including any tim | e for treatment and |
| 5, | Will the employee be incapacitat recovery? 11 No [] Yes | | | | |
| | If so, estimate the beginning and | i a uling dates for i | he period of incapacity | | |
| | | | ent appointments of W | ork part-time or on | a reduced schedule |
| б. | Will the employee need to atten because of the employee's medi | o low-up neam | No [] Yes | L | in [] Yes |
| | If so, are the treatments or the r | or med number of | hours of work medica | appointments and | the time required for |
| | If so, are the treatments or the f Estimate treatment schedule, it each appointment, including ar | 1 ly, including the | dates of any schedule | 20 Wol | es andis |
| | in lead to | - History | very 2 sol | et fry | til 36 (|
| | Estimate the part-time or redu | | the employee needs, r | My C | - way |
| | | mark from | to | | forming his/her job |
| | 7. Will the condition cause episc functions? [] No X Yes | 1 = flare-ups perio | dically preventing the | employee nom p | |
| | functions? [] No XX es Is it medically necessary for | a contovee to be | absent from work dur | ing the flare-ups? | [] No Yes |
| | Is it medically necessary for | Sint. | how to | Park | henry |
| | Nain | | 2 C OUN X (| To be addition | estimate the frequenc |
| | Based upon the patient's me flare-ups and the duration o | | our knowledge of the rethat the patient may h | ave over the next (| months (e.g., 1 episo |
| 71 | every 3 months lasting 1-2 | 1 -160 | 6 month(s) | , | |
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| Page | 3 | CONTIN | | | |
| | Santha Kamineni MD Lic 217178 | | | | |
| | DEA BK6747490 | | | | |

LTR032 - New Leave Request P ((Non California, For Self)

Version 2.1

0001/0001

| | Kristina Mikhaylova Payroll # 72061886 Store #72001 |
|------|---|
| 2)/. | 3.美导型检查的(1) 15 15 15 15 15 15 15 15 15 15 15 15 15 |
| 5. | Will the employee be incapacitated for a single continuous period of time, including any time for treatment and recovery? [] No [] Yes |
| | If so, estimate the beginning and ending dates for the period of incapacity: |
| 6. | Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? YINO [] Yes |
| | If so, are the treatments or the reduced number of hours of work medically necessary? M No [] Yes |
| | Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: Sulling any recovery period: |
| | Estimate the part-time or reduced work schedule the employee needs, if any: |
| 7. | Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? [] No [X Yes] Is it medically necessary for the employee to be absent from work during the flare-ups? [] No [Yes] If so, explain: |
| 4/ | Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days): Frequency: Times per week(s) month(s) Duration: 9 hours or days per episode |
| W | DEPENDENT REPORTED FOR THE TELEVISION OF THE VOICE OF THE VOICE AND THE |
| | CONTINUED ON NEXT PAGE |

Case 1:19-cv-08927-GBD-SLC Document 143-1 Filed 10/31/23 Page 42 of 53



Leave of Absence P.O. Box 17427 Clearwater, FL 33762 Fax: 1-800-310-7740 Ph: 1-800-234-MACY (6229)

Email:

bloomingdales.loa@bloomingdales.com

6/9/2017 Payroll # 72061886

Kristina Mikhaylova 7330 198 St Apt 1 Fresh Meadows, NY 11366

REF: Intermittent Leave Request

Dear Kristina,

We have received your health care certification dated 6/1/2017 for:

[X] Intermittent leave under FMLA

[] Other applicable intermittent leaves:

Based on the health care provider's certification you qualify for intermittent leave for absences related to this medical condition.

The attached Designation Notice provides additional information concerning your leave.

As with any absence, it is your responsibility to notify the store by following the call-out procedure and an immediate supervisor (for executives) when you are unable to work your regular scheduled shift, including absences related to the approved intermittent leave.

In addition, you must report your time to HR Services Leave of Absence within 2 business days upon your return to work of your inability to work a shift due to absences related to your approved intermittent leave. This time can be reported in two ways:

- Access Insite and select the Leave of Absence option under the Life Events menu option, then select the Report Intermittent Time option.
- Contact HR Services at 1-800-234-MACY (6229).

If you do not report the related absence to HR Services within the designated time-frame, then the absence might not qualify for approved intermittent leave and would then be addressed in accordance with Bloomingdale's attendance policy.

It is your responsibility to maintain a current health care certification on file. Bloomingdale's may periodically request recertification during your approved intermittent leave.

Please fax all updates/re-certification's to HR Services at 1-800-310-7740. It is important that your name and payroll number are clearly identified on all correspondence. If you have any questions, please contact HR Services at 1-800-234-MACY (6229).

Sincerely, Demario J Rodriguez HR Services, Leave of Absence

Bloomingdale's Purposes Only Kristina Mikhaylova Payroll # 72061886

Designation Notice (Family and Medical Leave Labor Act)

U.S. Department of **Employment** Standards Administration Wage and Hour Division



Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c)

Kristina Mikhaylova 6/9/2017

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on 6/8/2017 and decided:

Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

- Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will [] be counted against your leave entitlement: [] Hours [] Days [] Weeks.
- [X] Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

- You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against [] your FMLA leave entitlement.
- We are requiring you to substitute or use paid leave during your FMLA leave.
- [] You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position [] is [] is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.
- [] Additional information is needed to determine if your FMLA leave request can be approved: The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than 6/16/2017, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.
- [] We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.
- Your FMLA Leave request is Not Approved.
- The FMLA does not apply to your leave request. []
- [] You have exhausted your FMLA leave entitlement in the applicable 12-month period

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.



Leave of Absence P.O. Box 17427 Clearwater, FL 33762 Fax: 1-800-310-7740 Ph: 1-800-234-MACY (6229)

Email: bloomingdales.loa@bloomingdales.com

6/9/2017

Kristina Mikhaylova 7330 198 St Apt 1 Fresh Meadows, NY 11366

Payroll # 72061886

Dear Kristina:

We have been notified that you are requesting a Leave of Absence for 04/23/2017 to (approximately) 11/21/2017. Enclosed you will find important information about your Leave of Absence and the documentation required in order for the Company to approve and/or continue your leave. It is important that you understand your responsibilities during your leave so please review this information carefully. If you have any questions regarding this information or what is requested, please contact us.

Important – If you have not provided a health care certification your leave will be pending and not approved. All information requested must be mailed or faxed to the HR Services Leave of Absence team to the address above. HR Services will administer your leave request. If you need assistance in completing the forms, or if there are circumstances that prevent you from meeting the deadlines, please call the HR Services Leave of Absence team at 1-800-234-MACY (6229) or your HR Manager as soon as possible. Remember to stay in contact with your HR Manager regarding the status of your leave.

Please complete the following forms, sign and return to HR SERVICES within 15 days. If we do not receive this information from you within 15 days, your leave may be delayed or denied.

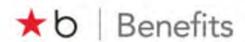
- Certification of Health Care Provider Needed
- Request for Leave of Absence Form Needed
- Notice of Eligibility and Rights & Responsibilities to Employee Request for Family Medical Leave (FMLA) Needed

Short Term Disability Benefit Information

If you are enrolled in a Short Term Disability plan at Macy's and if your leave is approved, you may be eligible to file a claim for Bloomingdale's Short Term Disability Benefit. Please see "Your Benefits While on Leave", Short Term Disability Pay section. If you have any questions about your eligibility please call 1-800-234-MACY (6229).

Sincerely,

Demario J Rodriguez HR Services Leave of Absence Team



Leave of Absence P.O. Box 17427 Clearwater, FL 33762 Fax: 1-800-310-7740

Ph: 1-800-234-MACY (6229)

| | Email: bloomingdales.loa@bloomingdales.com |
|----------------------------------|--|
| | |
| From: Kristina Mikhaylova | |
| Payroll #: 72061886 | |
| Date: | |
| Number of Pages Including Cover: | |
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| Comments: | |
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| information related t | to your leave of absence. |
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<u>Kristina Mikhavlova</u>

Pavroll # 72061886

Store #72001

Certification of Health Care Provider for U.S. Department of Labor **Employee's Serious Health Condition** (Family and Medical Leave Act)

Employment Standards Administration Wage and Hour Division



SECTION I: For completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

| Employer nan | yer name and contact: Bloomingdale's HR Services Leave of Absence, 1-800-234-MACY (6229) | | | | |
|--|---|--|--|--|--|
| Employee's jo | ployee's job title: Regular work schedule: | | | | |
| Employee's es | Employee's essential job functions: | | | | |
| Check if job d | escription is attac | hed: [] | | | |
| SECTION II: | : For completion | by the EMPLOYEE | | | |
| The FMLA per support a required to complete and | ermits an employe est for FMLA lea obtain or retain the sufficient medical | r to require that you submit ve due to your own serious e benefit of FMLA protecti l certification may result in | Section II before giving this form to your medical provider. It a timely, complete, and sufficient medical certification to health condition. If requested by your employer, your response ons. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a a denial of your FMLA request. 20 C.F.R. § 825.313. Your this form. 29 C.F.R. § 825.305(b). | | |
| Your name: | Kristina | | Mikhaylova | | |
| | First | Middle | Last | | |
| SECTION II | I: For completion | n by the HEALTH CARE | PROVIDER | | |
| fully and compoundation, treat examination of sufficient to describe the su | pletely, all applica Atment, etc. Your f the patient. Be a | able parts. Several question answer should be your best as specific as you can; term coverage. Limit your respon | : Your patient has requested leave under the FMLA. Answer, as seek a response as to the frequency or duration of a t estimate based upon your medical knowledge, experience, and as such as "lifetime," "unknown," or "indeterminate" may not be uses to the condition for which the employee is seeking leave. | | |
| Nondiscrimina or requiring go this law. To c for medical in results of an ir or received ge | ation Act of 2008 enetic information omply with this la formation. "Genet dividual's or faminetic services, and | (GINA) prohibits employen of an individual or family aw, we are asking that you tic Information" as defined ily member's genetic tests, d genetic information of a f | led by the Company: The Genetic Information rs and other entities covered by GINA Title II from requesting member of the individual, except as specifically allowed by not provide genetic information when responding to this request by GINA, includes an individual's family medical history, the the fact that an individual or individual's family member sought etus carried by an individual or an individual's family member mber receiving assistive reproductive services. | | |
| Provider's nan | ne and business ac | ldress: | | | |
| • • | ce / Medical speci | ialty: | | | |
| Telephone: | () | | Fax: () | | |
| Page 1 | | CONTINUED ON | NEXT PAGE | | |

| Kristina Mikhaylova | Payroll # 72061886 | Store #720 | | | |
|---|--|---|--|--|--|
| ion commenced: | | | | | |
| ndition: | | | | | |
| l for an overnight stay in a ho | ospital, hospice, or residential medic | cal care facility? | | | |
| eatient for condition: | | | | | |
| nan over-the-counter medicat | ion, prescribed? [] No [] Yes | | | | |
| have treatment visits at least | twice per year due to the condition? | []No []Yes | | | |
| | | | | | |
| Is the medical condition pregnancy? [] No [] Yes. If so, expected delivery date: Leave may be available for either baby bonding or in the event of a serious health condition. Please indicate the | | | | | |
| d for each category: | | | | | |
| | | | | | |
| | | | | | |
| s during the leave, please prov | vide updated medical certification. | | | | |
| loyee's essential functions or | tion I to answer this question. If the a job description, answer these que | employer fails to stions based upon the | | | |
| o perform any of his/her job | functions due to the condition? [] | No [] Yes. | | | |
| nctions the employee is unab | le to perform: | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | ble: If for an overnight stay in a hotes of admission: batient for condition: batient for condition: | ble: d for an overnight stay in a hospital, hospice, or residential medicates of admission: patient for condition: han over-the-counter medication, prescribed? [] No [] Yes have treatment visits at least twice per year due to the condition? to other health care provider(s) for evaluation or treatment (e.g., te the nature of such treatments and expected duration of treatments and expected duration of treatments are in the pregnancy? [] No [] Yes. If so, expected delivery date: or either baby bonding or in the event of a serious health condition. If of or each category: s during the leave, please provide updated medical certification. wided by the employer in Section I to answer this question. If the cloyee's essential functions or a job description, answer these que | | | |

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| Kristina Mikhavlova | Payroll # 72061886 | Store #72001 |
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| ixi istilia iviikila yluva | 1 ay1011 # 12001000 | Store #12001 |

| 5. | Will the employee be incapacitated for a single continuous period of time, including any time for treatment and recovery? [] No [] Yes |
|----|--|
| | If so, estimate the beginning and ending dates for the period of incapacity: |
| 6. | Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? [] No [] Yes |
| | If so, are the treatments or the reduced number of hours of work medically necessary? [] No [] Yes |
| | Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: |
| | Estimate the part-time or reduced work schedule the employee needs, if any: |
| | hours per day days per week from to |
| 7. | Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? [] No [] Yes |
| | Is it medically necessary for the employee to be absent from work during the flare-ups? [] No Yes If so, explain: |
| | |
| | Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days): |
| | Frequency: times per week(s) month(s) |
| | Duration: hours or days per episode |
| ΑI | DITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER |
| | |

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CONTINUED ON NEXT PAGE

| | Kristina Mikhaylova | <u>Payroll # 72061886</u> | Store #72001 |
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| Signature of Health Care Provide | er | Date | |

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

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<u>Kristina Mikhaylova</u> <u>Payroll # 72061886</u> <u>Store #7200</u>

REQUEST FOR LEAVE OF ABSENCE

- You may fax completed forms to HR Services 1-800-310-7740
- If you need assistance completing the forms, please contact your Human Resource Manager or HR Services at 1-800-234-6229(MACY).

| Date | Leave to Begin: | (Approximate) Date | e Leave to End: | - |
|----------|---|--|--|---------------------|
| | I request that I be granted " Original Leave of A Extension to my Le | bsence | | |
| I am | requesting my leave for t | he following reason: | | |
| <i>j</i> | A serious health condition A serious health conditionmy spousedonchildparent | that prevents me from perform the for which I need to provide nestic partner (as defined by | Company policy) | |
| " Т | o care for a qualified ill/in | ancy or pregnancy related of jured military service memb | | |
| V | lilitary leave (USERRA) | e is on leave from qualified i | military deployment | |
| | Other: please explain | | | |
| Inte | nplete only if requesting leave or ermittent/Reduced hour schedu eason for change in schedule- | | Proposed Schedule | |
| l uno | derstand that: | | | |
| 1. 2. | leave is to end. If I cannot return Resources Manager. I agree to Manager and/or HR Services to I will remain an employee of | n to work on this date, I must request a submit any additional supporting media support my leave of absence and/or a | cted to return to work on or before the date indicated an extension of my leave from my HR Services and H cal certification or documents requested by my Huma ny extension. leave of absence unless my position is eliminated as | uman In Resource |
| 3. | employment, or be self-employe | d, if it is inconsistent with the restrictio | orking at another place of employment. I may not ac ns provided by my Health Care Provider. Such action | |
| 4. | Insurance premiums that I a entitled to receive. I must direct | y pay any premiums not collected via | ntomatically from any disability pay or salary continual payroll deductions, to Bloomingdale's. Failure | |
| 5. | For certain leaves, I may be leave available to me. Please re | efer to the paid time off policy for accru | aid time off first. This may include PTO, holidays, or a all while on leave of absence. | |
| 6. 7. | days prior to the date indicated a | | t least 2 weeks prior if possible and no later than 2 (to lo so may result in a delay in my return to work. s during my leave. | wo) business |

What Next?

Employee Signature:

You may fax completed forms to 1-800-310-7740 or bloomingdales.loa@bloomingdales.com. If you need assistance completing the forms, please contact your Human Resource Manager or HR Services at 1-800-234-6229(MACY).

Date:

Kristina Mikhaylova

Payroll # 72061886

Store #72001

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act) U.S. Department of Labor Employment Standards Administration Wage and Hour Division



In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[PART A - NOTICE OF ELIGIBILITY]

To: Kristina Mikhaylova

From: HR Services - Leave of Absence

Date: 6/9/2017

On 06/08/2017 you informed us that you needed leave beginning on 04/23/2017 for:

- The birth of a child, or placement of a child with you for adoption or foster care;
- [X] Your own serious health condition;
- Because you are needed to care for your [] spouse; [] child; [] parent due to his/her serious health condition.
- Because of a qualifying exigency arising out of the fact that your [] spouse; [] son or daughter; [] parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- Because you are the [] spouse; [] son or daughter; [] parent; [] next of kin of a covered service member with a serious injury or illness.

This notice is to inform you that you:

- [X] Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
- [] Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- [] You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately months towards this requirement.
- [] You have not met the FMLA's 1,250-hours-worked requirement.
- [] You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact HR Services at 1-800-234-MACY or view the FMLA poster located in your store HR location.

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| Kristina Mikhaylova | Payroll # 72061886 | Store #72001 |
|---------------------|-------------------------------|----------------|
| [PART B - RIGHTS AI | ND RESPONSIBILITIES FOR TAKII | NG FMLA LEAVE] |

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by 6/24/2017. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

| [X] | Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request [X] is/ [] is not enclosed. | | |
|--|---|--|--|
| [] | Sufficient documentation to establish the required relationship between you and your family member. | | |
| [] | Other information needed: | | |
| If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply): | | | |

- [x] If you are enrolled in benefits contact HR Services/Benefits at 1-800-234-6229(MACY) to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.
- [] You will be required to use your available paid [] accrued PTO, and/or [] other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.
- [] Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We [] have/[] have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.
- [x] While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every 30 days. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave changes and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave: You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:

| [] | the calendar year (January – December). |
|-----|--|
| [] | a fixed leave year based on |
| [] | the 12-month period measured forward from the date of your first FMLA leave usage. |
| [x] | a "rolling" 12-month period measured backward from the date of any FMLA leave usage. |

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| Kristina Mikh | naylova | Payroll # 72061886 | <u>Store #72001</u> | |
|---------------|------------------|----------------------------|-------------------------------------|-------------------------|
| • | You have a right | under the FMLA for up to 2 | 6 weeks of unpaid leave in a single | 12-month period to care |

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care
 for a covered service member with a serious injury or illness. This single 12-month period commenced on
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as
 if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and
 conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end
 of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered service member's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- if we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have [] accrued sick days, [x] accrued PTO (as applicable) and/or [x] other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.
- [x] For a copy of conditions applicable to sick days/PTO/other leave usage please refer to the information under your benefits while on leave and/or the company PTO policy.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

1-800-234-MACY (6229)

| I acknowledge that when I notified the Co of my rights and obligations and answere | empany of my need for Family Medical Leave Act, the Company provided me with notice d any questions I had presented. |
|--|--|
| Date | Signature of Employee |
| This form will need to be mailed to: | Leave of Absence P.O. Box 17427 |

Clearwater, FL 33762-0427